STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395295	A. BLDG: 00 B. WING:	04/19/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MURRYSVILLE REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: **134702**	**3300 LOGANS FERRY ROAD MURRYSVILLE, PA 15668**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, Civil Rights Compliance Survey, State Licensure Survey and an Abbreviated survey in response to two complaints, completed on April 19 2023, it was determined that Murrysville Rehabilitation and Wellness Center, was not in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long-Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long-Term Care Licensure Regulations.	F 0000		
F 0641 SS=D		F 0641		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0641 SS=D	Continued from page 1 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	The facility will ensure that Minimum Data Set (MDS) assessments accurately reflect the resident's status for all residents. Resident R31's MDS (Section K) was updated to accurately reflect resident's swallowing/nutritional status accurately. The Dietitian or designee will complete a house audit of residents' Section K of MDS assessments to ensure that their swallowing/nutritional status is accurately reflected. The Regional Dietitian Consultant or designee will reeducate registered dietitian on facility's MDS/RAI Care Planning policy and how to accurately complete Section K of MDS assessments. The Dietitian or designee will audit to ensure new admissions and residents with change of condition will have an accurate Section K of MDS assessments to ensure that swallowing/nutritional status is	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/28/2023**

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F 0641 SS=D	Continued from page 2	F 0641	accurately reflected. These audits will be completed 3x weekly for four weeks and then monthly for three months. These audits will be forwarded to monthly Quality Assurance and Performance Improvement Committee for review, recommendations, and frequency of audits.	

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F 0641 SS=D	Continued from page 3 Based on review of the Resident Assessment Instrument (RAI) user's manual (gives instructions for completing Minimum Data Set - periodic assessment of care needs), facility policy, clinical records and staff interview, it was determined that the facility failed to ensure that Minimum Data Set (MDS- periodic assessment of care needs) assessments accurately reflected the resident's status for one of three residents (Resident R31). Findings include: The RAI User's Manual, dated October 2019, indicated Section K, K0100: Swallowing Disorder do not code a swallowing problem when interventions have been successful in treating the problem and therefore the sign/symptoms of the problem (K0100A through K0100D) did not occur during the 7-day look-back period. A review of facility policy "MDS/RAI/Care Planning" dated 2/22/23, indicated that each discipline of the interdisciplinary team, will be	F 0641		

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F 0641 SS=D	Continued from page 4 responsible to sign the MDS attestation statement to certify that his/her section is accurate and complete. A review of the clinical face sheet indicated that Resident R31 was admitted to the facility 2/10/15, with diagnosis that included non-traumatic subarachnoid hemorrhage (bleeding within the subarachnoid space, an area between the brain and the tissue covering the brain), dysphagia (a condition with difficulty in swallowing food or liquid) following cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area), and quadriplegia (a condition where both the arms and legs are paralyzed). A review of Resident R31's Quarterly MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 2/1/23, indicated that diagnoses remain current upon review. A review of the recapitulation of physician orders, as of 4/18/23, indicated that Resident R31 is NPO	F 0641		

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F 0641 SS=D	Continued from page 5 (nothing by mouth, a medical instruction meaning to withhold food and fluids). Further review of clinical records current care plan, initiated 2/10/15, revised 2/21/23, indicated Resident R31 is dependent on tube feeding (a way of delivering nutrition directly to your stomach or small intestine) related to chronic dysphagia and inability to meet needs via oral (by mouth) means. Interview conducted on 4/18/23, at 10:15 a.m., Registered Nurse Employee E11 confirmed that Resident R31 is NPO (nothing by mouth), and has been since admission to facility. Further review of Resident R31's Quarterly MDS assessment dated 2/1/23, indicated the following: Section K. Swallowing Disorder, Signs and Symptoms of possible swallowing disorder Check all that apply: K0100A. Loss of liquids/solids from mouth while eating or drinking was checked/coded with a "X" K0100B. Holding food in mouth/cheeks or residual	F 0641		

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F 0641 SS=D	Continued from page 6 food in mouth after meals was checked/coded with a "X" K0100C. Coughing or choking during meals or when swallowing medications was checked/coded with a "X" K0100D. Complaints of difficulty or pain with swallowing was checked/coded with a "X" Review of clinical records, Nutrition Status Review - Quarterly, dated 2/12/23, indicated resident R31 is receiving enteral nutrition support and Diet/Meal intake is NPO (nothing by mouth). Further review of Nutrition Status Review - Quarterly failed to indicate that Resident R31 was having signs/symptoms of possible swallowing disorder during the 7-day look-back period for Quarterly MDS assessment reference date (ARD) of 2/1/23. During an interview conducted on 4/18/23, at 10:00 a.m., Registered Dietitian Employee E12 confirmed that Resident R31's Quarterly MDS Assessment dated 2/1/23, was incorrectly checked/coded in error with an "X" for Section K0100 (K0100A	F 0641		

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F 0641 SS=D	Continued from page 7 through K0100D). During an interview conducted on 4/19/23, at 9:45 a.m., Registered Nurse Assessment Coordinator (RNAC) Employee E13 confirmed that Resident R31's Quarterly MDS assessment, dated 2/1/23, Section K0100, was coded in error, and that the facility failed to ensure that MDS assessments accurately reflected the resident's status for one of three residents (Resident R31). 28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.	F 0641		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 8 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	The facility will ensure that care plans for all residents are revised/updated to accurately reflect the current status of the resident. Resident R55's care plan was updated to accurately reflect the resident's significant weight loss and use of oral nutritional supplements. The Director of Nursing or designee will complete a house audit of residents' care plans with a significant weight loss or residents currently using oral nutritional supplements to ensure that their care plans accurately reflect the residents' status. The Director of Nursing or designee will reeducate licensed nurses, including agency and new hires, on facility's MDS/RAI Care Planning policy and the requirement for the care plans to accurately reflect the resident's status. The Director of Nursing or designee will audit to ensure new admissions and residents with change of	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/28/2023**

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F 0657 SS=D	Continued from page 9	F 0657	condition related to significant weight loss and the use of oral nutritional supplements will have an updated care plan to accurately reflect the residents' status. These audits will be completed 3x weekly for four weeks and then monthly for three months. These audits will be forwarded to monthly Quality Assurance and Performance Improvement Committee for review, recommendations, and frequency of audits.	

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F 0657 SS=D	Continued from page 10 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to revise/update care plans for one of five residents to accurately reflect the current status of the resident (Resident R55). Findings include: A review of facility policy "MDS/RAI/Care Planning" dated 2/22/23, indicated that the Resident Assessment Instrument (RAI) and Care Planning Process provide a tool for an interdisciplinary approach to plan the care of the resident. Residents will have a comprehensive assessment completed by day 14 of stay and a Comprehensive Care Plan completed and reviewed within 7 days of the completion date of the MDS. The resident will then be assessed at least quarterly and care plan reviewed by the interdisciplinary team according to OBRA schedule and more often if required for Medicare reimbursement. A review of the clinical face sheet indicated that	F 0657		

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F 0657 SS=D	Continued from page 11 Resident R55 was admitted to the facility 10/26/22, with diagnosis that include bacterial infection, lung cancer, and rectal cancer. A review of Resident R31's Quarterly MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 3/3/23, indicated that diagnoses remain current upon review. A review of Resident R31's 5 day MDS assessment dated 1/19/23, Section K0300, Weight Loss was coded as a "2, yes, not on physician-prescribed weight-loss regimen", which indicated weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. Further review of Resident R31's Quarterly MDS assessment dated 3/3/23, Section K0300, Weight Loss was coded as a "2, yes, not on physician-prescribed weight-loss regimen", which indicated significant weight loss of 5% or more in the last month or loss of 10% or more in last 6 months.	F 0657		

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F 0657 SS=D	Continued from page 12 A review of Resident R31's clinical record, Nutrition Status Review - Quarterly, dated 3/4/23, indicated a significant decrease of 29.3% (82#) over past 180 days. Recommendations were made to begin nutritional treat twice a day with lunch and dinner. A review of Resident R31's clinical record, active physician orders as of 4/18/23, indicated that Resident R55 is ordered Nutritious Treat Cup two times a day with lunch and dinner, initiated 3/7/23, and Nutritious Shake with meals, initiated 4/10/23. A review of Resident R31's current care plan failed to indicate goals and interventions for significant weight loss, and failed to indicate oral nutritional supplement (Nutritious Treat Cups and Nutritious Shakes) as interventions for nutritional problems. During an interview conducted 4/19/23, at 9:45 a.m., RNAC Employee E13 confirmed that the facility failed to revise/update the care plan to accurately reflect the current status of Resident	F 0657		

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F 0657 SS=D	Continued from page 13 R55's significant weight loss and use of oral nutritional supplements. 28 Pa. Code: 211.11(d) Resident care plan. 28 Pa. Code: 211.12(d)(5) Nursing services.	F 0657		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 14 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	The facility will ensure that a physician is notified of abnormal glucose levels via a Capillary Blood Glucose (CBG) level as per order for all residents who require CBG testing. Facility notified attending physician notification of abnormal blood glucose levels for resident R64 on dates 3/18/23 and 3/20/23. The Director of Nursing or designee will complete a house audit of CBG monitoring summaries for the last thirty days for residents who require CBG testing to ensure physician notifications were made for residents recorded to have abnormal blood glucose levels. The Director of Nursing or designee will reeducate licensed nurses, including agency and new hires, on facility's "Notification of Changes" policy and requirement to notify physician for all residents recorded to have abnormal blood glucose levels. The Director of Nursing or designee	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/28/2023**

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F 0684 SS=D	Continued from page 15 [redacted] services.	F 0684	will audit to review CBG monitoring summaries for residents who require CBG testing and ensure physician notifications are made when an abnormal blood glucose level is recorded. These audits will be completed 3x weekly for four weeks and then monthly for three months. These audits will be forwarded to monthly Quality Assurance and Performance Improvement Committee for review, recommendations, and frequency of audits.	
F 0726 SS=E		F 0726		

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F 0726 SS=E	Continued from page 16 483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 0726	The facility will complete timely resident rights competencies for facility staff. Resident rights competencies will be completed for Employees E4 through E9. The facility has scheduled a mandatory resident rights inservice for all facility staff, including agency and new hires, on May 4th to ensure facility staff is provided with resident rights training and competencies. The Nursing Home Administrator or Designee will re-educate the Human Resources Director, the facilitator of staff education, on federal regulation 0726, detailing providing facility staff with timely required annual resident rights education. The Nursing Home Administrator will complete an audit of 10 personnel records weekly for four weeks then monthly for three months to validate employees have received timely annual resident rights education.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/28/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395295	A. BLDG: __00_____ B. WING: _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MURRYSVILLE REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: **134702**	**3300 LOGANS FERRY ROAD MURRYSVILLE, PA 15668**

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F 0726 SS=E	Continued from page 17	F 0726	The results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement Committee for review and frequency of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0726 SS=E	Continued from page 18 Based on review of facility policy, personnel records and staff interview, it was determined that the facility failed to complete timely annual resident rights competencies for six out of seven sampled personnel records (Nurse Aide (NA) Employee E4, NA Employee E5, NA Employee E6, Licensed Practical Nurse (LPN) Employee E7, Registered Nurse (RN) Employee E8, and LPN Employee E9). Findings include: The facility "Staff development" policy last reviewed 2/22/23, indicated that the facility will provide staff development and education to employees. There shall be ongoing coordination of education program which is planned and conducted including training related to resident rights. All employees receive mandatory in-services annually and include resident rights, privacy, and dignity. Review of NA Employee E4's personnel record indicated she was hired 7/11/11.	F 0726		

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F 0726 SS=E	Continued from page 19 Review of NA Employee E5's personnel record indicated he was hired 6/4/91. Review of NA Employee E6's personnel record indicated she was hired 7/3/17. Review of LPN Employee E7's personnel record indicated he was hired 10/27/19. Review of RN Employee E8's personnel record indicated she was hired 8/30/11. Review of LPN Employee E9's personnel record indicated she was hired 7/24/06. Review of annual in-services for NA Employee E4, NA Employee E5, NA Employee E6, LPN Employee E7, RN Employee E8, and LPN Employee E9 did not include a 2022 annual in-service on resident rights. During an interview on 4/18/23, at 11:30 a.m. the	F 0726		

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F 0726 SS=E	Continued from page 20 Director of Human Resources Employee E10 confirmed the facility failed to complete timely annual resident rights competencies for NA Employee E4, NA Employee E5 ,NA Employee E6 , LPN Employee E7 , RN Employee E8, and LPN Employee E9 as required. 28 Pa. Code 201.20(a)(b)(d) Staff development. 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 211.12(d)(1)(5) Nursing services	F 0726		
F 0732 SS=C		F 0732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0732 SS=C	Continued from page 21 483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 0732	The facility will ensure current nursing staffing hours are posted on a daily basis as required. Facility immediately posted current nursing staffing hours for 4/16 when identified by surveyor. The administrator or designee will re-educate the Human Resources Director/Scheduler on federal tag F-0732 and the requirement to post nursing staffing hours on a daily basis. The administrator or designee will complete an audit 5x weekly for four weeks and monthly for three months to ensure nursing staffing hours are posted as required. These audits will be forwarded to monthly Quality Assurance and Performance Improvement Committee for review, recommendations, and frequency of audits.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/28/2023**

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F 0732 SS=C	Continued from page 22 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 0732		

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F 0732 SS=C	Continued from page 23 Based on observation and staff interview, it was determined that the facility staff failed to display current nurse staffing hours on a daily basis as required. Findings include: During an entrance observation on Sunday 4/16/23, at 8:30 a.m. in the main entrance lobby, posted nurse staffing hours were dated Wednesday 4/12/23. During an interview on Sunday 4/16/23, at 9:27 a.m. the Nursing Home Administrator confirmed the above observation and that the facility failed to display current nurse staffing hours on a daily basis as required. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1) Nursing services.	F 0732		
F 0757 SS=D		F 0757		

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F 0757 SS=D	Continued from page 24 483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 0757	The facility will ensure residents have appropriate diagnosis for the administration of antipsychotic medications. Resident R63 Haldol medication will be reviewed by the physician, and if indicated, an appropriate diagnosis will be added for the continued use of the medication, or the medication will be discontinued. A house audit will be completed to validate residents ordered the antipsychotic medication Haldol have an appropriate diagnosis for its use. The Director of Nursing or Designee will re-educate licensed nurses, including new hires and agency, on the facility policy and procedures for medication administration, detailing ensuring appropriate diagnosis for the use of Haldol an antipsychotic medication. The Director of Nursing or Designee will complete an audit weekly for four weeks then monthly for three	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/28/2023**

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F 0757 SS=D	Continued from page 25	F 0757	months to validate residents have the appropriate diagnosis for the use of Haldol. The results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement Committee for review and frequency of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0757 SS=D	Continued from page 26 Based on review of facility policy and clinical record review, and staff interviews, it was determined that the facility failed to administer medication for an appropriate diagnosis for one of six residents (Resident R63) Findings include: Review of facility policy "Antipsychotic Drugs" last reviewed 2/23/23, indicated residents who have not used antipsychotic drug therapy are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. Review of Resident R63's Minimum Data Set (MDS - periodic assessment of care needs) dated 1/31/23, indicated the resident was admitted on 6/11/20 and current diagnosis included vascular dementia without behaviors (memory and other thought processes caused by brain damage from impaired blood flow to your brain) paranoid schizophrenia (characterized by predominantly	F 0757		

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F 0757 SS=D	Continued from page 27 positive symptoms of schizophrenia, including delusions and hallucinations), and high blood pressure. Review of Resident R63's physician order dated 5/15/22, indicated Haldol (manages symptoms of schizophrenia including hallucinations and delusions) 1.5 milligrams was ordered two times a day for agitation. During an interview on 4/19/23, at 11:47 a.m. the Director of Nursing confirmed that agitation is not a proper diagnosis for Haldol, and the facility failed to have an appropriate diagnosis for the administration of an antipsychotic. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.2(a)Physician services. 28 Pa. Code 211.9(a)(1) Pharmacy services. 28 Pa. Code 211.12(d)(1) Nursing services.	F 0757		

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F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 29 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	The facility will accurately label medications in accordance with state and federal regulations. The opened multi dose injector Saxenda and the opened in use Lantus injector pen have been discarded and were replaced with pens labeled with resident names. A house audit will be completed to ensure injector medication pens are labeled with resident names. The Director of Nursing or Designee will re-educate licensed nurses, including new hires and agency, on the facility policy and procedures for storage and labeling of medications, detailing ensuring injector medication pens are labeled with resident names. The Director of Nursing or Designee will complete an audit two times a week for four weeks then monthly for three months to validate injector medication pens are labeled with resident names and stored appropriately.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/28/2023**

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F 0761 SS=D	Continued from page 30	F 0761	The results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement Committee for review and frequency of audits.	

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F 0761 SS=D	Continued from page 31 Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to accurately label medications as required in one of five medication carts (Cart 49) Findings include: Review of facility policy "Labeling of Medications" indicated all medications maintained in the facility are properly labeled in accordance with current state and federal regulations. Labels for individual drug containers must contain the resident's name. During an observation on 4/17/23, at 11:10 a.m. the facility Medication Cart 49, had an open in use Saxenda (multi dose injector that treats obesity and injects medicine just under the skin) injector pen, that failed to have a medication label with a residents name, and a open in use Lantus insulin (treats diabetes and injects long acting insulin just under the skin) injector pen that failed to have a medication label with a residents name.	F 0761		

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F 0761 SS=D	Continued from page 32 During an interview on 4/17/23, at 1:23 p.m. the Director of Nursing confirmed the above observation, and that the facility failed to have medication labels with resident names on multi dose injector pens, as required. 28 PA Code 211.9: (a)(1)(h) Pharmacy services 28 PA Code 211.12: (1)(2) Nursing services.	F 0761		
F 0812 SS=F		F 0812		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MURRYSVILLE REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: **134702**	**3300 LOGANS FERRY ROAD MURRYSVILLE, PA 15668**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 33 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	The facility will ensure kitchen equipment is maintained in a sanitary condition to prevent cross contamination in the main kitchen of the facility. Facility immediately removed debris from fan covers and the ceiling in walk-in cooler of the main kitchen when identified by surveyor on 4/16. Maintenance inspected facility's other walk-in cooler and freezer to validate that the fan covers and ceilings were free from debris. The Regional Dietitian or designee will educate dietary staff on the facility's "Sanitation" policy which outlines the requirement to main kitchen equipment in a sanitary condition to avoid cross-contamination. The administrator or designee will complete an audit 5x weekly for four weeks and then weekly for three months to validate that the fan covers and ceilings in the facility's walk in cooler and freezer are free	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/28/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395295	A. BLDG: __00_____ B. WING: _____	04/19/2023

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MURRYSVILLE REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: **134702**	**3300 LOGANS FERRY ROAD MURRYSVILLE, PA 15668**

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F 0812 SS=F	Continued from page 34	F 0812	from debris. The results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement Committee for review and frequency of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MURRYSVILLE REHABILITATION AND WELLNESS CENTER	**3300 LOGANS FERRY ROAD MURRYSVILLE, PA 15668**
STATE LICENSE NUMBER: **134702**	

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F 0812 SS=F	Continued from page 35 Based on a review of policy, observation and staff interview, it was determined that the facility failed to properly maintain kitchen equipment in a sanitary condition creating the potential for cross contamination in the main kitchen of the facility. Findings include: A review of facility "Sanitation" policy dated, 2/22/23, indicated the food service area shall be maintained in a clean and sanitary manner. During an observation made on 4/16/23, at 10:20 a.m., of the walk-in cooler in the designated main kitchen of the facility revealed that cold air condenser fan covers and the ceiling immediately forward of these cooler fans had a build-up of dust, grime, and debris. During an interview made on 4/16/23, at 10:20 a.m., Food Service Cook Employee E2 confirmed that the walk-in cooler fan covers and the ceiling immediately forward of the cooler fans had a	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395295	A. BLDG: 00 B. WING:	04/19/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MURRYSVILLE REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: **134702**	**3300 LOGANS FERRY ROAD MURRYSVILLE, PA 15668**

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F 0812 SS=F	Continued from page 36 built-up of dust, grime, and debris. During an interview made on 4/17/23, at 10:10 a.m., Regional Dietitian Employee E3 confirmed that the facility failed to maintain clean and sanitary equipment creating the potential for cross contamination in the Main Kitchen. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.6(c) Dietary services.	F 0812		
F 0847 SS=D		F 0847		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0847 SS=D	Continued from page 37 483.70(n)(2)(i)(ii)(3)-(5) Entering into Binding Arbitration Agreements §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.	F 0847	The facility will ensure residents have the capacity to understand the terms of a binding agreement before signing the paperwork. The facility will destroy the arbitration agreement signed by Resident R244, the facility will review and explain the arbitration agreement to the resident representative. The facility will complete a house audit and review existing resident arbitration agreements to validate if signed by a resident they have the capacity to understand the terms of the agreement. The Nursing Home Administrator or Designee will re-educate the Admissions Director on the Federal regulation 0847 and the requirements for entering into arbitration agreements, detailing ensuring the residents have the capacity to understand the terms of the agreement. The Nursing Home Administrator or Designee will complete an audit	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/28/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0847 SS=D	Continued from page 38 §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by:	F 0847	weekly for four weeks then monthly for three months to validate the facility is complying with the regulation for Arbitration Agreements and that the residents have the capacity to understand the terms of the agreement. The results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement Committee for review and frequency of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0847 SS=D	Continued from page 39 Based on review of facility documents and resident clinical record and staff and resident interviews it was determined that the facility failed to ensure a resident had the capacity to understand the terms of a binding arbitration agreement for one of three residents (Resident R244). Findings include: Review of Resident R244's admission Minimum Data Set dated 4/19/23, indicated she was admitted on 4/13/23, and her Brief Interview for Mental Status Score (BIMS - test of cognitive ability) score was 3 (indicated severe cognitive impairment). Review of Resident R244's clinical record indicated she has current diagnosis of Alzheimers Dementia (progressive disease that destroys memory and other important mental functions),seizures and urinary tract infections. . Review of Resident R244's Binding Arbitration Agreement (a binding agreement by the parties to	F 0847		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0847 SS=D	Continued from page 40 submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) indicated she signed the document on admission on 4/13/23. During an interview on 4/19/23, at 8:53 a.m. with the Social Worker Employee E14 and Resident R244, the resident was confused at baseline and could not recall signing any paper work. The Social Worker Employee E14 confirmed this was her baseline cognitive status During an interview on 4/19/23, at 9:00 a.m. the Admission Director Employee E15 confirmed the facility failed to ensure resident R244 had the capacity to understand the terms of a binding arbitration agreement. 28 Pa. Code 201.24 (b) Admission Policy	F 0847		

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F 0847 SS=D	Continued from page 41 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.29(a)(j) Resident Rights	F 0847		

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P 1600		P 1600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1600	Continued from page 1 § 209.8(b) Fire Drills. (b) A written report shall be maintained of each fire drill which includes date, time required for evacuation or relocation, number of residents evacuated or moved to another location and number of personnel participating in a fire drill. This REGULATION is not met as evidenced by:	P 1600	The facility will accurately maintain written fire drill reports that will include time required for evacuation or relocation of residents. The facility cannot retroactively correct the concerns identified during survey. The facility immediately revised the fire drill form to include time required for evacuation or relocation of residents. The Nursing Home Administrator or Designee will re-educate the Maintenance Director on Regulation 1600 and maintaining fire drill logs that include time required for evacuation or relocation of residents. The Nursing Home Administrator will review the fire drill logs monthly for four months to validate the required time for evacuation of relocation of residents is documented. The results of these audits will be	Completion Date: **05/23/2023** Status: **APPROVED** Date: **04/28/2023**

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P 1600	Continued from page 2	P 1600	forwarded to the monthly Quality Assurance and Performance Improvement Committee for review and frequency of audits.	

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P 1600	Continued from page 3 Based on review of the facility's fire drill logs and staff interview, it was determined that the facility failed to accurately maintain written fire drill reports that are required to include the time required for evacuation or relocation for twelve of twelve months (April, May, June, July, August, September, October, November, December 2022, January, February, and March 2023.) Findings Include: A review of facility policy "Fire, Safety, Disaster, and Emergency Preparedness" dated 2/22/23, indicated the facility will conduct monthly fire drills. Review of the Fire Alarm Reports did not include documentation to indicate the time required for evacuation or relocation during the twelve months reviewed, April 2022 through March 2023. During an interview on 4/18/23, at 12:40 p.m. the Nursing Home Administrator confirmed that the facility did not record the time for evacuation or relocation for twelve of twelve months as required.	P 1600		

Certified End Page

MURRYSVILLE REHABILITATION AND WELLNESS CENTER

STATE LICENSE NUMBER: 134702

SURVEY EXIT DATE: 04/19/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY